

EPI—NOTES



Hillsborough County Health Department

Disease Surveillance Newsletter



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CONTACT DERMATITIS IN DAYCARE FACILITIES

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During March and April of the past three years, several daycare facilities in Hillsborough County have reported rash illnesses among children. Many of these daycare facilities have experienced the same rash outbreaks each year during these months. Physician diagnoses of the affected children have ranged from chickenpox, to scabies, to flea bites, to contact dermatitis, to a nonspecific viral rash. Most of the affected children have presented with contact dermatitis. A low-grade fever has been reported in a small minority of the children.

All of these daycare facilities reported the presence of caterpillars on the premises during these rash illness outbreaks. The daycare centers report significant contact between many of the children and the caterpillars. A search of the scientific literature and a conversation with a Department of Agriculture and Consumer Affairs entomologist confirmed that caterpillars can cause contact dermatitis and, previously, have been linked to outbreaks. It is interesting to note that caterpillar infestations can last for several years at a time, followed by years without the appearance of this species of caterpillar.

Researchers have documented several instances in which individuals suffered the effects of contact dermatitis with tussock moth caterpillars. In 1990 in Singapore, a rash illness occurred in 141 residents of an apartment building. These rashes were linked to the tussock moth caterpillar, which were largely prevalent at that time (Ooi, et al., 1991). Another infestation of tussock moth caterpillars caused rash illnesses in 56 people at a Boy Scout camp in New Mexico in July of 2000. A survey of the campers demonstrated that those campers with direct caterpillar contact, those with a history of eczema, and those sleeping at the most infested campsite were most likely to suffer a rash illness (Redd & Voorhees, 2000).

At this time, the daycare facilities are being advised to eliminate contact between the children and the caterpillars. When the numbers of caterpillars are very high, the irritating caterpillar hairs can also become airborne and cause general skin and conjunctival (eye) irritation, so people experiencing rashes may need to stay out of the infested areas entirely. If a child needs medical attention, his or her physician should be told about any caterpillar infestations occurring at the daycare facility. Questions can be directed to the Hillsborough County Health Department Epidemiology Program, phone (813) 307-8010.

References

Ooi, P.L., Goh K.T., Lee, H.S., Goh, C.L. (1991). Tussockosis: an outbreak of dermatitis caused by tussock moths in Singapore. *Contact Dermatitis*, 24(3), 197-200.

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FUSARIUM KERATITIS --- MULTIPLE STATES, 2006

Excerpts from MMWR April 10, 2006 / 55(Dispatch); 1-2.

Web: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm55d410a1.htm>

An ongoing investigation by CDC, state and local health departments, and the Food and Drug Administration is under way to determine whether a cluster of *Fusarium* keratitis, in multiple states, represents an increase of the infection or an association with any product. Epidemiologic and laboratory studies will help define specific activities, hygiene practices, or products that place persons at increased risk for *Fusarium* keratitis.

Microbial keratitis is a severe infection of the cornea. Risk factors for infection include trauma (generally with plant material), chronic ocular surface diseases, immunodeficiencies, and rarely, contact lens use (1--3). An estimated 30 million persons in the United States wear soft contact lenses; the annual incidence of microbial keratitis is estimated to be 4--21 per 10,000 soft contact lens users, depending on whether users wear lenses overnight (4). Fungal keratitis is a condition more prevalent in warm climates; in the southernmost United States, up to 35% of microbial keratitis cases are fungal keratitis, compared with 1% in New York (5,6). The proportion of fungal keratitis attributable to *Fusarium* spp. also varies by region, from 25% to 62% (1,2,5). First-line treatment includes topical and oral antifungal medications; patients who do not respond to medical treatment usually require surgical intervention, including corneal transplantation (3). *Fusarium* keratitis is not transmitted from person to person.

Measures to reduce the risk for microbial keratitis can be instituted immediately by contact lens users and include the safe handling, storage, and cleaning of contact lenses. Specifically, contact lens users should wash their hands with soap and water and dry them before handling lenses, wear lenses according to the schedule prescribed by eye-care practitioners and solution manufacturers, and follow guidelines for cleaning and storing lenses provided by eye-care practitioners and solution manufacturers. Contact lens users with questions about which solutions are best for them should consult their eye-care professionals and carefully weigh risks and benefits.

Clinicians evaluating contact lens users with signs or symptoms of keratitis, such as unusual redness, eye pain, tearing, discharge, or sensitivity to light, should consider fungal keratitis and refer the patient to an ophthalmologist, if appropriate. Clinicians should consider obtaining clinical specimens (e.g., corneal scrapings) for culture before initiating treatment. Clinicians or microbiology laboratories should report cases of *Fusarium* keratitis to state and local health departments. *Fusarium* isolates should be submitted to state laboratories according to instructions provided by local and state public health laboratories.

Additional case finding is currently underway and new cases of *Fusarium* keratitis may be reported to the Hillsborough County Health Department at (813) 307-8010.

References

1. Rosa RH Jr, Miller D, Alfonso EC. The changing spectrum of fungal keratitis in south Florida. *Ophthalmology* 1994;101:1005--13.
2. Tanure MA, Cohen EJ, Sudesh S, Rapuano CJ, Laibson PR. Spectrum of fungal keratitis at Wills Eye Hospital, Philadelphia, Pennsylvania. *Cornea* 2000;19:307--12.
3. Thomas PA. Fungal infections of the cornea. *Eye* 2003;17:852--62.
4. Poggio EC, Glynn RJ, Schein OD, et al. The incidence of ulcerative keratitis among users of daily-wear and extended-wear soft contact lenses. *N Engl J Med* 1989;321:779--83.
5. Liesegang TJ, Forster PK. Spectrum of microbial keratitis in south Florida. *Am J Ophthalmol* 1980;90:38--47.
6. Asbell P, Stenson S. Ulcerative keratitis. Survey of 30 years' laboratory experience. *Arch Ophthalmol* 1982;100:77--80.

HILLSBOROUGH COUNTY HEALTH DEPARTMENT Data Summary Report

DISEASE	2003 Yr end	2004 Yr end	2005 Yr end	3YR AVG (2002-2004)	Jan-Mar 05	Jan-Mar 06
AIDS	194	377	346	305.7	82	108

DISEASE	2003 Yr end	2004 Yr end	2005 Yr end	3YR AVG (2002-2004)	Jan-Mar 05	Jan-Mar 06
ANIMAL BITE, PROPHY REC.	24	17	30	23.7	7	0
ANTHRAX	0	0	0	0.0	0	0
BOTULISM	0	1	0	0.3	0	0
BRUCELLOSIS	0	2	0	0.7	0	0
CAMPYLOBACTERIOSIS	72	59	45	58.7	10	6
CHLAMYDIA	3,071	2,964	3,208	3,081.0	846	877
CIGUATERA	0	0	0	0.0	0	0
CREUTZFELDT-JAKOB DISEASE	0	2	0	0.7	0	0
CRYPTOSPORIDIOSIS	7	13	32	17.3	3	6
CYCLOSPORIASIS	0	0	40	13.3	0	0
DENGUE	0	1	3	1.3	0	0
DIPHTHERIA	0	0	0	0.0	0	0
EHRlichiosis, HUMAN GRANULOCYTIC	1	0	0	0.3	0	0
EHRlichiosis, HUMAN MONOCYTIC	0	0	0	0.0	0	0
ENCEPHALITIS, CALIFORNIA/LACROSSE	0	1	0	0.3	0	0
ENCEPHALITIS, HERPES	0	1	1	0.7	0	0
ENCEPHALITIS, NON-ARBOVIRAL	0	0	0	0.0	0	0
ENCEPHALITIS, OTHER	0	0	0	0.0	0	0
ENCEPHALITIS, EEE	0	0	0	0.0	0	0
ENCEPHALITIS, SLE	0	0	0	0.0	0	0
ENCEPHALITIS, WN	0	3	0	1.0	0	0
ESCHERICHIA COLI (E. COLI) O157:H7	2	4	6	4.0	2	0
E. COLI SHIGA TOXIN + NON-O157	0	0	0	0.0	0	0
E. COLI, OTHER	0	0	0	0.0	0	0
FOOD AND WATERBORNE CASES	163	210	114	162.3	102	17
FOOD AND WATERBORNE OUTBREAKS	33	22	9	21.3	6	7
GIARDIASIS	71	62	64	65.7	11	19
GONORRHEA	1,643	1,197	1,261	1,367.0	317	353
H. INFLUENZAE PNEUMONIA	1	3	5	3.0	1	0
H-FLU, PRIMARY BACTEREMIA	2	3	4	3.0	1	2
HANSEN'S DISEASE (LEPROSY)	1	0	0	0.3	0	0
HANTAVIRUS	0	0	0	0.0	0	0
HEMOLYTIC UREMIC SYNDROME	0	0	1	0.3	0	0
HEPATITIS A, ACUTE	40	27	14	27.0	2	4
HEPATITIS B, ACUTE	76	60	41	59.0	6	5
HEPATITIS B, MATERNAL (HBsAg+ Pregnant)	43	42	41	42.0	7	6
HEPATITIS B, PERINATAL ACUTE	0	0	0	0.0	0	0
HEPATITIS B, CHRONIC*	234	203	145	194.0	28	18
HEPATITIS C, ACUTE	10	9	3	7.3	1	0
HEPATITIS C, CHRONIC*	479	1,184	827	830.0	111	173
HEPATITIS NON-A NON-B, ACUTE	0	0	1	0.3	0	0
HEPATITIS UNSPEC, ACUTE	1	0	1	0.7	0	0
HIV INFECTION	363	366	332	353.7	79	93
LEAD POISONING	49	37	29	38.3	15	0
LEGIONELLOSIS	12	10	9	10.3	2	1
LEPTOSPIROSIS	0	0	0	0.0	0	0
LISTERIOSIS	2	0	1	1.0	0	0
LYME DISEASE	3	1	7	3.7	0	0

MALARIA	4	5	9	6.0	0	2
MEASLES	0	1	0	0.3	0	0
DISEASE	2003 Yr end	2004 Yr end	2005 Yr end	3YR AVG (2002-2004)	Jan-Mar 05	Jan-Mar 06
MENINGITIS, GROUP B STREP	2	3	4	3.0	2	1
MENINGITIS, H-FLU	1	4	1	2.0	0	0
MENINTITIS, LISTERIA MONO	0	0	0	0.0	0	0
MENINGITIS, OTHER	14	15	15	14.7	2	2
MENINGITIS, S PNEUMO	7	7	6	6.7	2	3
MENINGOCOCCAL DISEASE	3	4	4	3.7	1	1
MERCURY POISONING	0	0	0	0.0	0	0
MUMPS	3	1	2	2.0	1	0
PERTUSSIS	4	3	34	13.7	7	12
PESTICIDE RELATED ILLNESS	0	0	0	0.0	0	0
POLIO, PARALYTIC	0	0	0	0.0	0	0
PSITTACOSIS	0	1	0	0.3	0	0
Q FEVER	1	0	0	0.3	0	0
RABIES ANIMAL	11	9	7	9.0	5	3
ROCKY MOUNTAIN SPOTTED FEVER	1	1	0	0.7	0	1
RUBELLA	0	0	0	0.0	0	0
SALMONELLOSIS	263	233	299	265.0	27	25
SHIGELLOSIS	31	49	251	110.3	6	42
SMALLPOX	0	0	0	0.0	0	0
STAPH AUREUS VISA/VRSA	0	0	0	0.0	0	0
STREP DISEASE, INVASIVE GROUP A	11	18	7	12.0	0	0
STREP PNEUMO, INVASIVE DRUG RESIST	59	50	46	51.7	14	26
STREP PNEUMO, INVASIVE SUSCEPTIBLE**	14	39	35	29.3	7	14
SYPHILIS, CONGENITAL	3	1	0	1.3	0	0
SYPHILIS, INFECTIOUS	43	47	41	43.7	11	7
TETANUS	0	0	0	0.0	0	0
TOXOPLASMOSIS	3	2	0	1.7	0	0
TUBERCULOSIS	77	73	51	67.0	13	18
TYPHOID FEVER	0	2	1	1.0	0	0
VIBRIO ALGINOLYTICUS	0	3	1	1.3	0	0
VIBRIO CHOLERA NON-01	0	0	0	0.0	0	0
VIBRIO HOLLISAE	0	0	0	0.0	0	0
VIBRIO PARAHAEMOLYTICUS	2	0	2	1.3	1	0
VIBRIO VULNIFICUS	5	5	2	4.0	0	0
VIBRIO, OTHER	0	0	0	0.0	0	0
WEST NILE FEVER	1	0	0	0.3	0	0
YELLOW FEVER	0	0	0	0.0	0	0

Data contained in this report are
provisional

NA=NOT AVAILABLE NR=NOT REPORTABLE

**Added
Sept. 2003

*Data collection began October 2002

Epi-Notes is a free newsletter produced by the Hillsborough County Health Department disease control programs to provide local information and promote disease reporting. **Please share this information with interested health care providers.** To add or remove your name from the Epi-Notes list please email your request to dawn_morgan@doh.state.fl.us or fax to 813-276-2981. We welcome your comments. The editorial staff consists of Dr. Albert Vincent, Michael Kilcomons, Eliot Gregos, David Atrubin, Xiomara Hewitt-Jeffrey, and Jylmarie Kintz. The Hillsborough County Health Department, Epidemiology Program, distributes Epi-Notes, 1105

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